Call for Papers: Conference on "Triage in Medicine II: The Extension of a Paradigm?"

Dates: 5th and 6th December 2024

Venue: Amphitheatre Buffon, Université Paris Cité (Paris 13th)

The concept of triage in healthcare, derived from wartime and disaster medicine, refers to the prioritisation of patients, determining the order of care and ultimately, who will be treated or not. This concept is fraught with ethical dilemmas and social, political, and medical taboos, as highlighted during the SARS-CoV-2 pandemic. While political and institutional leaders refuted the existence of hospital triage, healthcare professionals argued that triage was a routine practice, implemented according to known, transparent, and strictly medical criteria. The former highlighted the morally and politically unacceptable exclusion from care that triage entails, whereas the latter emphasised the necessary prioritisation to optimise resources, all while continuing to put individual patient interest above collective considerations.

These positions obscure the existence and complexity of various triage modalities leading to the exclusion of some patients from care, a responsibility that neither policymakers nor healthcare professionals wish to assume. Denying the existence of medical triage or limiting its application to collectively discussed practices in resource scarcity contexts appears to be a strategy to render ordinary triage practices invisible. Yet, the extent of these practices is documented and debated, particularly through the concept of a triage continuum (Leichter-Flack 2014). Although triage is highly publicised in emergencies or disaster instances where its practice is explicit and regulated - while raising major ethical questions (Iserson and Moskop 2007; Persad, Wertheimer, and Emanuel 2009; Koch 2012; Emanuel et al. 2020), it remains under-publicised and scarcely questioned outside of these contexts. Its management then falls more under political and medical decisions, as well as economic and social dynamics often unknown to citizens, healthcare users, and even healthcare professionals themselves.

In 2012, an interdisciplinary conference revealed that triage constituted the underside of care, not just an action reserved for situations of medical resource scarcity. The resulting publication, *La médecine du tri. Histoire, anthropologie, éthique*, demonstrated that triage could be seen as a foundation of modern medical practice (Lachenal, Lefève, and Nguyen 2014), and it was more broadly linked to contemporary biopolitics (Fassin 2018). It began to document various fields of triage: emergency services, organ transplantation, addiction treatment, cardiac surgery, reproductive medicine, neurovascular unit, palliative care, Health service access points (PASS), HIV/AIDS, research protocols, etc. At the height of the COVID-19 pandemic, the concept of triage was analysed as a tool for examining the healthcare system in its entirety (Gaudillière, Izambert, and Juven 2021). Clinical triage performed among individuals appeared to stem from a systemic triage applied to populations, influenced by multiple determinants related to health

policies, such as weaknesses in prevention, lack of coordination between hospital and community-based health services, territorial inequalities in healthcare provision, etc.

During the pandemic, triage was addressed by healthcare professionals, social science researchers, and the National Ethics Advisory Committee (November 2020), as a denial to be lifted and a prism through which to interrogate ordinary and informal health practices. However, the public debate on this issue of social justice and health democracy faded, returning to invisibility. Resource management in healthcare reverted to the domain of health policies and professionals, missing an opportunity for public debate on resource allocation, which the pandemic could have initiated.

This conference aims to continue documenting the diversity of settings and practices in prioritisation and triage, to understand the extension of the triage paradigm in contemporary medicine, and to relate triage operations to their political, social, and economic contexts, as well as the constraints that influence the principles, values, and choices of the actors involved. It also seeks to provide an overview of the knowledge in social sciences and humanities on medical triage, and to continue and promote the research, debates, and inquiries that the health crisis has allowed to (re)open: How have triage practices been (re)configured? What continuities and/or disruptions can we describe? What contextual changes explain their development? How has triage been affected by the pandemic, the 'shortage' of healthcare workers, and the transformation of hospital services, such as emergency departments? How do these practices and/or their transformation modify medical work and the interactions between patients and healthcare professionals? How is triage discussed in the media? These questions can be addressed from various perspectives, the following list being provisional and non-exhaustive.

"Public Policies"

We hypothesise that public policies and their development contribute to different forms of triage, organising resource scarcity and conditioning access to care. Triage, when approached from public policies, operates on multiple levels. It is embodied in the very definition of health needs and the decisions made by public policies, reflecting power dynamics (e.g., HIV/AIDS). This process continues in the way public action intermediaries implement these policies, an implementation shaped by the tensions and power struggles within their environments, whether these are conflicts between different professional segments or between various occupational groups with divergent interests. It culminates in the direct encounters between professionals and patients.The organisational and managerial configuration of health services, as well as their structuring into specialised care pathways, have a significant impact on access to care and its quality (Vassy 2004, Belorgey 2012, Morel 2016, Geeraert 2021). These continuums of triage manifest in palliative care (Thay and Lefève 2023), as well as in the fields of HIV/AIDS and COVID-19 vaccination (Gelly 2023). Additionally, the processes of appropriation and privatisation of health goods lead to an unequal distribution of these resources (Gelly 2023).

Submissions are expected to address the influence of public policy development processes on the shaping of triage and on social health inequalities. Proposals that explore original settings or respond to contemporary issues of health democracy, such as staff shortages, bed closures, medical deserts, territorial planning, and drug supply disruptions, which highlight the triage approach in medicine, are particularly welcome. Communications that tackle these issues

through the study of outpatient or private practice medicine and its links with the hospital environment, or that extend these analyses to the study of less-documented pathologies, will be especially appreciated. Research that deepens the understanding of these issues in already explored fields is equally welcome.

"Triage Tools"

Public policies require tools, some specifically developed for triage, which offer varying degrees of flexibility to users. Attention could be given to different triage tools, their development, implementation, and effects on triage processes. Some tools influence or organise triage, like activity-based funding (T2A) which encourages profitable pathologies for institutions, or "ViaTrajectoire," a healthcare orientation tool that, in practice, leads to patient selection by professionals. Triage tools allow for varying degrees of execution, less for emergency triage devices than for general clinical practice recommendations. Administrative barriers to care, linked to residency or social coverage access, should also be considered as triage tools.

To be effectively implemented, these public policies require the support of tools, some specifically designed for this purpose. These tools provide varying degrees of flexibility for the actors who use them. Particular attention could be given to the various triage tools, the conditions of their development, their implementation, and the effects of their use on triage processes. Indeed, some existing tools influence or organise triage. For example, activity-based funding (T2A) promotes the selection of conditions deemed "profitable" for institutions (Juven, Pierru, and Vincent 2019). Furthermore, the different triage systems allow for varying degrees of execution. They are less extensive for emergency triage systems than for clinical best practice recommendations, which are often more general and less specifically regulated (Trépos and Laure 2010). Finally, administrative barriers to care, strongly linked to access to residency permits and social protection, should also be considered as "triage tools" (Georges-Tarragano 2015; Izambert 2016; Gabarro 2022).

"Work and Professional Practices"

Social science research on healthcare professionals' practices sheds light on triage. The study of formalised triage, like that performed by emergency room triage nurses, shows that clinical and ethical issues intertwine with professional distinction and the preservation of working conditions. Some papers could examine triage from this perspective, linking professional roles and dynamics with medical triage practices. However, the triage performed by healthcare professionals can also appear in non-formalised and partially invisible forms.

Since the 1960s, social science research has highlighted the triage of patients based on social criteria. These studies have shown that people seeking healthcare do not all have equal access to services, not only depending on the severity of their condition but also according to their social status. For instance, social status affects how doctors allocate scarce therapeutic resources that could prolong patients' lives (Glaser and Strauss 1968). In recent years, this research, somewhat overlooked by French health sociology, has seen a resurgence of interest, particularly through the notion of patients' "social value" (Paillet 2021). The differentiated practices of

healthcare professionals, which contribute to the reproduction of social health inequalities, have been increasingly documented. This is notably seen in a double issue of the journal Actes de la recherche en sciences sociales: "Santé Critique 1 et 2". The interplay of social factors (notably gender, class, and race) in the interactions between patients and healthcare providers, resulting in differentiated care, has also been the focus of significant studies (Sauvegrain 2012; Prud'Homme 2016; Loretti 2019; Darmon 2021). This literature particularly addresses the hospital setting and specific pathologies.

Submissions that document how the working conditions of healthcare professionals can amplify or, conversely, reduce these informal triage practices will be particularly appreciated. Special attention could also be given to patient selection practices motivated by financial incentives, particularly in private medical and paramedical practice. For example, discussions could focus on the impact of extra billing practices and the current struggles of a branch of the medical profession to extend sector 2, which allows doctors to set their own fees above the standard rates covered by health insurance. Finally, in order to diversify the study of triage practices, significant attention could be given to less-documented subjects, such as the long and uncertain processes of recognition and compensation for occupational diseases (Marchand 2022).

"Patients"

Finally, participants are invited to document how patients navigate triage practices Are these identified by patients? If so, what strategies do they adopt in this competition that can oppose them? How do these strategies vary according to their social, economic, and cultural capital, and their "health consciousness" (Arborio and Lechien 2019)? Additionally, social mobilisations around these issues could shed light on the conditions that make it possible (or not) to open discussions on triage.

The compartmentalised presentation of these themes as different focus areas is intended only to guide the proposals. We welcome the articulation of these dimensions in papers, as well as their historicisation. Research addressing triage from other angles or on distant fields will be well-received. Proposals on triage media coverage will be given special attention.

The concept of triage is inherently interdisciplinary, both in its definitions and its issues. We invite proposals from sociological, historical, or philosophical perspectives, highlighting ethical tensions, especially between public health logic and the singularity of the care relationship. Epistemological analyses exploring how triage helps establish and shape norms concerning patients, caregiving practices, and disease conceptions are also welcome.

Submission Guidelines:

- Proposals (in English or in French) should be sent to the following email address: medecinedutri2024@gmail.com
- Abstract: maximum of 3000 characters (excluding bibliography)
- Must include the following elements: Name of the author(s), institutional affiliations, contact email, title of the communication, research methodology.

Scientific Committee:

Nicolas Belorgey, sociologist, CNRS Research Fellow, Paris Dauphine – Irisso
Sophie Crozier, neurologist, cerebrovascular intensive care unit -Assistance Publique-Hôpitaux de Paris
Céline Gabarro, sociologist, Associate Professor at the University of Lille – CeRIES
Guillaume Lachenal, historian, Professor at Sciences Po – Médialab
Milena Maglio, philosopher, Espace Ethique Ile de France – SPHère
Sylvie Morel, sociologist, Associate Professor at the University of Nantes – CENS
Laure Pitti, sociologist, Associate Professor at the University of Paris 8 - Cresspa

Organising Committee:

Céline Lefève, philosopher, Professor at Université Paris Cité (SPHère), Director of the Centre Georges Canguilhem and the La Personne en médecine institute
Cyril Knecht, PhD student in Sociology (USPN-IRIS).
Inès Labainville, PhD student in Sociology (INSERM-USPN-IRIS)
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